KELLY'S HOME THERAPY SERVICES, LLC

Houston, TX 77062-2527
Phone: 281.309.1981 FAX: 832.284.4732

Patient Name:____ SSN:______________________________

DOB: ____________ Married_____Single____Widowed ____ Divorced_____Separated_____Appointment Date:_________

Address:______________________________________City_______________________State________Zip__________

Home Phone:___________________________________ Work Phone:____________________________________

Cell Phone:_____________________________________Email:____

Employer and/or School:______________________________ How did you hear about us?_______________________

Reason for Visit:____

Is there a court order that affects the parent-child relationship? YES____ NO____
If yes, which conservator has the right to consent to psychological treatment? ___________________________

Primary Insurance:________________________________ Policy/ID #____

Group#____ Benefit phone#___________________________________

Secondary Insurance:_____________________________ Policy/ID #____

Group#____ Benefit phone#___________________________________

Insured's Name____
(if different from patient)

DOB________________________Employer:____

Relationship to patient self ______ spouse _____ child _____ other _____, explain___________________________

Responsible Party: ____
(if different from patient; this must be filled out if patient is a child)

Address:______________________________________City_____________________State_________Zip_____________

Home Phone:____ Work Phone:______________________________

Cell Phone:____Email:_________________________________

Employer:____School:___________________________________

In Case of Emergency:______________________________________Phone #__________________________

Primary Care Physician ____________________________________Phone # ______________________________

Medical Conditions: ____

____

Your signature below indicates that you have read the Agreement and the Notice of Privacy Practices and agree to their terms and indicates acceptance of therapy.

____
Patient Signature Date